Guidelines for Patient Centered Medical Home (PCMH) Demonstration Projects

PCPCC Endorsed—March 2009

The following chart outlines the guidelines for PCMH demonstration projects developed by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA), which the PCPCC endorsed in March 2009.

These guidelines are designed to help ensure that demonstration projects purporting to test the PCMH model are broadly consistent with the Joint Principles.[1] In addition, the standardization promoted by the acceptance of these guidelines will help facilitate more meaningful interpretation and understanding of the "lessons learned" from the different PCMH demonstration projects.

Collaboration and Leadership	1. The project is open to input from all relevant stakeholders. Examples of relevant stakeholders include professional societies, payers, local large employers/purchasers, health care-oriented community groups including patient advocacy groups, and representatives from local/regional quality improvement programs. 2. The project ensures that the leaders of local/regional primary care professional organizations are adequately briefed about the project. 3. The project identifies an entity that is responsible for convening all participants and coordinating the activities of the project.
Practice Recognition	4. The project uses the National Committee for Quality Assurance (NCQA) Physicians Practice Connections (PPC) PCMH tool, or a similar, consensus-based recognition process that includes validation of PCMH practice attributes defined in the "Joint Principles."[2] 5. The project includes participation of a range of practice sizes, and is representative of the area in which the project is taking place. 6. The project clearly outlines the responsibilities of all participating parties, including providers, payers, patients/families and other relevant stakeholders.
Practice Support	7. The project provides participating practices with sufficient financial and non-financial support to at least cover the costs of the PCMH recognition approval process; additional physician, clinical staff, and administrative staff work associated with the project; and implementation of the practice infrastructure required to provide services consistent with the PCMH care model. 8. The project encourages the incorporation of and support for Health Information Technology (HIT) solutions to facilitate: Care Management and Care Coordination by the medical team; Patient and Family Access to educational material and electronic communications; and/or Performance Reporting (including the Patient/Family Experience, Quality Outcomes and Improvement, and Healthcare Resource Utilization). 9. The project design maximizes the number of patients in each participating practice covered by the demonstration project. This can be accomplished in multiple ways, including the participation of multiple payers and the use of broad criteria for patient participation (e.g. child, adult, and elderly participants; patients with chronic and non-chronic conditions). *continued*

[1]American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, American Osteopathic Association. *Joint Principles of the Patient Centered Medical Home.* March 2007. Accessible at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

[2]Ibid.

Reimbursement Model	10. The project's payment model is broadly consistent with the following: • A prospective, bundled component that covers physician and administrative staff work and practice expenses linked to the delivery of services under the PCMH model not covered by the most current Medicare RBRVS system. • A visit-based fee component for services delivered as part of a face-to-face visit and that are already recognized by the most current Medicare RBRVS system. • A performance-based component based on the achievement of defined quality and efficiency goals as reflected by evidence-based quality, cost of care and patient experience measures. • The payment model should recognize differences in the level of PCMH care provided and patient case mix/complexity.
Assessment and Reporting of Results	11. The project provides evidence supporting that it is of sufficient duration to reasonably expect the impact of the model to be demonstrated. 12. The project contains a commitment to an external evaluation to ensure the integrity and credibility of the project's data and reports. 13. The project contains a commitment to transparency of the data set, including the selection, use and reporting of results from clinical metrics, financial measures and the application of proprietary measures of performance. 14. The project includes, at a minimum, the following data collection categories: • Descriptive data of the participating patients and practices. • Process and outcome measures of clinical quality with preference for those measures approved by the AQA and the National Quality Forum (NQF). • Measures of resources used, which can include cost of care to the payer and patient, and net effect of the care model on the financial performance of the participating practices. • Measures of patient/family experience of care with a preference for nationally recognized measures. • Measures of the experience and/or satisfaction of participating physicians, practice staff, and payers with the model. 15. The project measures the qualitative and quantitative (i.e., resource utilization) effects of the PCMH delivery and payment model on the broader health care community e.g., subspecialty and specialty practices, hospital/emergency room care. 16. The project includes a process to broadly and publicly disseminate its results.

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